Factors that may increase HIV testing uptake in those who decline to test

The aim of improving uptake of HIV testing is threefold: to reduce the proportion of undiagnosed HIV infection within the community; to ensure early access to treatment for those found to be infected; and to limit further transmission.[1] Little research has occurred within the United Kingdom to understand reasons why patients decline an offer of HIV testing. An aim of this study was to identify factors that would persuade patients who declined to have an HIV test, to test in an inner city sexual health clinic with a universal HIV testing policy.

We conducted a prospective questionnaire based survey of all patients of unknown HIV status presenting over a 2 month period. All patients who saw a doctor, except those attending for follow up, were invited to participate.

In all, 585 (49.4%) questionnaires were returned. There were no significant differences between responders and non-responders in terms of sex, age, STI, or HIV prevalence. Forty two per cent of all eligible patients reported that they were having an HIV test. Half (51.6%) of the patients who did not test for HIV reported that they felt at low risk of HIV as a reason for not testing. The second and third most common reasons were ''being too scared of the result'' (19.1%) and ''not wanting to know'' (14.2%). Reported sexual behaviours, previous STI diagnosis, and STI prevalence for patients who reported not testing because they considered themselves at low risk of HIV, were compared with patients who gave other reason(s) for not testing (table 1). In general, those who felt themselves to be at low risk of HIV tended to report fewer sexual risk behaviours.

In all, 198/225 who were not testing reported at least one situation that would make them consider testing. The main situations for which they would ''very likely'' consider testing were if a partner or ex-partner was HIV positive (97.1%, 95% CI: 93.2 to 99.1). Two thirds (63.6%, 95% CI: 52.7 to 73.6) of woman were ''likely'' or ''very likely'' to test if they became pregnant. The availability of medicines to treat HIV would make half (49.2%, 95% CI: 35.7 to 61.3) ''likely'' or ''very likely'' to test, while a cure for HIV would make two thirds (69.1%, 95% CI: 56.4 to 79.1) ''likely'' or ''very likely'' to test.

Overall, the analysis of reasons not to test and patient's appreciation of risk suggests people test as a response to behaviour and are aware of the risks. However, a substantial proportion of patients perceiving themselves at low risk, the principal reason for not testing, did have significant risk factors (for example, 36.1% reported unprotected sex with two or more partners in the past year, 46.3% had a previous STI diagnosis, and 9.6% a current STI diagnosis). Although participants appeared to be largely aware of the risks associated with their behaviours they did not appear to be aware of many of the benefits of testing. A substantial proportion of patients appeared unaware of the benefits of testing in terms of pregnancy or the availability of medicines to treat HIV. In the age of effective antiretroviral therapies, approximately half of patients not testing were ''likely'' or ''very likely'' to test if medicines were available to treat HIV. Promoting the benefits of combination antiretroviral therapies may significantly increase uptake of HIV testing.

Table 1 HIV risk perception by reported sexual behaviours and STI diagnosis among patients reporting that they were not having an HIV test (n = 218)

	Reported ''felt at low HIV risk'' as a reason for not testing for HIV				
	No		Yes		
	n/N	(%)	n/N	(%)	p Value*
Sexual behaviour					
2+ heterosexual partners, past year	52/86	(60.5)	42/104	(40.4)	0.006
2+ homosexual partners, past year	10/28	(35.7)	9/49	(18.4)	0.089
New partner(s) while abroad in past 5 years	26/75	(34.7)	22/87	(25.3)	0.192
Ever paid/been paid money for sex	4/96	(4.2)	9/113	(8.0)	0.257
Unprotected anal and/or vaginal sex with 2+ partners in past year	40/65	(61.5)	30/83	(36.1)	0.002
Unprotected vaginal sex with 2+ partners in past year	33/83	(40.2)	29/107	(27.1)	0.003
Unprotected anal sex with 2+ partners in past year	5/59	(8.5)	2/73	(2.7)	0.144
STI diagnosis					
Previous STI diagnosis	53/93	(57.0)	50/108	(46.3)	0.130
Current diagnosis†‡§	12/59	(20.3)	7/73	(9.6)	0.080
Chlamydia trachomatis	9/51†	(17.6)	7/60†	(11.7)	0.371
Genital herpes	1/5†	(20.0)	0/1†	(0.0)	0.624
Gonorrhoea	0/31†	(0.0)	0/39†	(0.0)	–
Trichonomas	5/50†	(10.0)	1/61†	(1.6)	0.053
Syphilis	0/50†	(0.0)	0/61†	(0.0)	–

*According to χ^2 statistic.
†Positive diagnosis within 1 week of completing questionnaire.
‡Not all patients tested for all STIs.
§Diagnosed with at least one of HIV, *Chlamydia trachomatis*, genital herpes, gonorrhoea, trichomonas, syphilis.

Contributors

FB and STS conceived and designed the study, helped to analyse and interpret the data, drafted and revised the article; CHM analysed the data and helped draft and revise the article; DM helped in study conception and design, and revision of the article; BC and PK helped in design of the study and final revision of the article.

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Reference

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HPV in cervix and vagina

Cervical cancer screening by Papanicolaou (Pap) smear has shown its use in reducing both incidence and mortality. Nowadays, cervical tumours are mostly diagnosed in women who were not, or not properly, screened. The invasive sampling method of screening is one of the reasons why women do not participate. The efficiency of cervical cancer screening could be increased if a less invasive test were available. Today, there is extensive scientific evidence that infection with high risk human papillomavirus (HPV) is associated with the development of cervical cancer. An international survey of more than 1000 cervical cancers showed that HPV DNA was present in 93% of all tumours.[1] Further investigation of the HPV negative carcinomas showed that, with improved methodology, 99.7% of all cervical tumours contained HPV DNA.[2] Recently, it has been suggested that self sampled vaginal material can be used for HPV detection. Several investigations—on a limited number of women—have shown a good correlation between self sampled vaginal material and a cervical sample taken by a professional.[3 4]

This study aimed to investigate the HPV prevalence in cervix and vagina on samples taken by a professional. Between October 2001 and March 2003, 159 women were enrolled in this study. Of these women, 96 visited their GP for a routine Pap smear, whereas 63 women, working as prostitutes, visited an STI clinic. The study protocol was approved by the medical ethics board of Antwerp University. The GP or STI doctor first took a vaginal sample using a polyurethane tipped swab (Culturette EZ, Becton Dickinson) and then, after inserting a speculum, a cervical sample using a Cervex-Brush (Rovers, Oss, Netherlands). Samples were treated as described previously.[5] HPV DNA amplification was performed using the GP5+/6+ HPV polymerase chain reaction (PCR).[6] Detection of PCR products was performed in an enzyme immunoassay format.[7] After detection of HPV with a HPV probe